Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1795HPC	A. BUILDING _____ B. WING _____	10/07/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTACARE	1625 E PRATER WAY, BLDG C #108 SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS Surveyor: 28383 This Statement of Deficiencies was generated as a result of a State Licensure survey and complaint investigation conducted in your facility on 10/06/2009 and finalized on 10/07/2009, in accordance with Nevada Administrative Code, Chapter 449, Provision of Hospice Care. Complaint #NV00022930 was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Twenty patient records were reviewed. Twenty eight employee records were reviewed. Three home visits were conducted. The following deficiencies were identified:	L 000		
L 069 SS=C	449.0186 REQUIREMENTS FOR PLAN OF CARE 2. A plan of care must: (c) State the scope and frequency of each service to be provided to the patient and members of his family. This Regulation is not met as evidenced by: Surveyor: 22048 Based on clinical record review and staff interview, the agency failed to provide services as ordered, by the physician, for each discipline on the plan of care. The visits provided to the patients did not meet the ordered frequency and duration on the plan of care for all patient records reviewed. (Patient #6, #18 and #20)	L 069		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 069	Continued From page 1 Three clinical records were reviewed for compliance to physician's orders regarding frequency of visits by the following disciplines: skilled nursing (SN), home health aide (HHA), spiritual care provider (SC) and Medical Social Worker (MSW). Patient #6 : The MSW made two out of the nine visits ordered. Patient #18: The SN made one visit in excess of the number of visits ordered. The HHA failed to make the required number of visits for 6 of 7 weeks. The SC continued to visit the patient for 3 of 3 weeks that it was not ordered. The MSW initial assessment was not done within 5 days of original order and failed to visit 2 of the 7 weeks it was ordered. Patient #20: The HHA failed to provide two aides three times a week for 4 of 8 weeks. The SC failed to make the ordered number of visits in 4 of 8 weeks. The MSW failed to make 2 of 2 visits ordered. Scope: 2 Severity: 2	L 069		